

Adjustment Disorders

Diagnostic Features

The essential features of an Adjustment Disorder is the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors. The symptoms must develop within 3 months after the onset of the stressor(s) (Criterion A). The clinical significance of the reaction is indicated either by marked distress that is in excess of what would be expected given the nature of the stressor, or significant impairment in social or occupational (academic) functioning (Criterion B). This category should not be used if the disturbance meets the criteria for Axis I disorder (e.g., a specific Anxiety or Mood Disorder) or is merely an exacerbation of a preexisting Axis I or II disorder (Criterion C). However an Adjustment Disorder may be diagnosed in the presence of another Axis I or Axis II disorder if the latter does not account for the pattern of symptoms that have occurred in response to the he stressor. The diagnosis of an Adjustment Disorder also does not apply when the symptoms represent Bereavement (Criterion D). By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor (or its (Criterion E). However, the symptoms may persist for a prolonged period (i.e., longer than 6 months) if they occur in response to a chronic stressor (e.g., a chronic, disabling general medical condition) or to a stressor that has enduring consequences (e.g., the financial and emotional difficulties resulting from a divorce).

The stressor may be a single event (e.g., termination of a romantic relationship), or there may be multiple stressors (e.g., marked business difficulties and marital problems). Stressors may be recurrent (e.g., associated with seasonal business crises) or continuous (e.g, living in a crime-ridden neighborhood). Stressors may affect a single individual, an entire family, or a larger group or community (e.g., as in a natural disaster). Some stressors may accompany specific developmental events (e.g., going to school, leaving the parental home, getting married, becoming a parent, failing to attain occupational goals retirement).

Subtypes and Specifiers

Adjustment Disorders are coded according to the subtype that best characterizes the predominant symptoms:

309.0 With Depressed Mood. This subtype should be used when the predominant manifestations are symptoms such as depressed mood, tearfulness, or feelings of hopelessness.

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309.3 With Anxiety. This subtype should be used when the predominant manifestations are symptoms such as nervousness, worry, or jitteriness or, in children, fears of separation from major attachment figures.

309.3 With Mixed Anxiety and Depressed Mood. This subtype should be used when the predominant manifestation is a combination of depress anxiety.

309.3 With Disturbance of Conduct. This subtype should be used when the predominant manifestation is a disturbance in conduct in which there is violation of the rights of others or of major age-appropriate societal norms and rules (e.g., truancy, vandalism, reckless driving, fighting, defaulting on legal responsibilities

309.4 With Mixed Disturbance of Emotions and Conduct This subtype should be used when the predominant manifestations are both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct (see above subtype).

309.9 Unspecified. This subtype should be used for maladaptive reactions (e.g., physical complaints,

social withdrawal, or work or academic inhibitions) to psychosocial stressors that are not classifiable as one of the specific Adjustment Disorder.

The duration of the symptoms of an Adjustment Disorder can be indicated by choosing one of the following specifiers:

Acute. This specifier can be used to indicate persistence of symptoms for less than 6 months.

Chronic. This specifier can be used to indicate persistence of symptom for 6 months or longer. By definition, symptoms cannot persist for more than 6 months after the termination of the stressor or its consequences. The Chronic specifier therefore applies when the duration of the disturbance is longer than 6 months in response to a chronic stressor or to a stressor that has enduring consequences

Reporting Procedures

The predominant symptom presentation for an Adjustment Disorder should be indicated by choosing the diagnostic code and term from the list above, followed, if desired by the Acute or Chronic specifier (e.g., 309.0 Adjustment Disorder With Depressed Mood Acute). In a multiaxial assessment, the nature of the stressor can be indicated by listing it on Axis IV (e.g., Divorce).

Associated Features and Disorders

The subjective distress or impairment in functioning associated with Adjustment Disorders is frequently manifested as decreased performance at work or school and temporary changes in social relationships. Adjustment Disorders are associated with an increased risk of suicide attempts and suicide. The presence of an Adjustment Disorder may complicate the course of illness in individuals who have a general medical condition (e.g., decreased compliance with the recommended medical regimen of hospital stay).

Specify Culture, Age, and Gender Features

The context of the individual's cultural setting should be taken into account in making the clinical judgment of whether the individual's response to the stressor is maladaptive or whether the associated distress is in excess of what would be expected. The nature, meaning, and experience of the stressors and the evaluation of the response to the stressor may vary across cultures. Adjustment Disorders may occur in any age group, and males and females are equally affected.

Prevalence

Adjustment Disorders are apparently common, although epidemiological figures vary widely as a function of the population studied and the assessment methods used. The percentage of individuals in outpatient mental health treatment with a principal diagnosis of Adjustment Disorder ranges from approximately 5% to 20%. Individuals from disadvantaged life circumstances experience a high rate of stressors and may be at increased risk for the disorder.

Course

By definition, the disturbance in Adjustment Disorder begins within 3 months of onset of a stressor and lasts no longer than 6 months after the stressor or its consequences have ceased. If the stressor is an acute event (e.g., being fired from a job), the onset of the disturbance is usually immediate (or within a few days) and the duration is relatively brief (e.g., no more than a few months). If the stressor or its consequences persist, the Adjustment Disorder may also persist.

Differential Diagnosis

Adjustment Disorder is a residual category used to describe presentations that are a response to an

identifiable stressor and that do not meet the criteria for another specific Axis I disorder. For example, if an individual has symptoms that meet criteria for a Major Depressive Episode in response to a stressor, the diagnosis of Adjustment Disorder is not applicable. Adjustment Disorder can be diagnosed in addition to another Axis I disorder only if the latter does not account for the particular symptoms that occur in the stressor. For example, an individual may develop Adjustment Disorder with Depressed Mood after losing a job and at the same time have a diagnosis of Obsessive-Compulsive Disorder. Because **Personality Disorders** are frequently exacerbated by stress, the additional of Adjustment Disorder is usually not made. However, if symptoms that are not characteristic of the Personality Disorder appear in response to a stressor (e.g., a person with Paranoid Personality Disorder develops depressed mood in response to job additional diagnosis of Adjustment Disorder may be appropriate. The diagnosis of Adjustment Disorder requires the presence of an identifiable stressor, in contrast to the atypical or subthreshold presentations that would be diagnosed as a **Not Otherwise Specified disorder** (e.g., Anxiety Disorder Not Otherwise Specified). If the symptoms of Adjustment Disorder persist for more than 6 months after the stressor or its consequences have ceased, the diagnosis should be changed to another mental disorder, usually in the appropriate Not Otherwise Specified category.

Adjustment Disorder, **Posttraumatic Stress Disorder**, and **Acute Stress Disorder** all require the presence of a psychosocial stressor. Posttraumatic Stress Disorder and Acute Stress Disorder are characterized by the presence of an extreme stressor and a specific constellation of symptoms. In contrast, Adjustment Disorder can be triggered by a stressor of any severity and may involve a wide range of possible symptoms.

In **Psychological Factors Affecting Medical Condition**, specific psychological symptoms, behaviors, or other factors exacerbate a general medical condition, complicate treatment for a general medical condition, or otherwise increase the risk of developing a general medical condition. In Adjustment Disorder, the relationship is the reverse (i.e., the psychological symptoms develop in response to the stress of having or being diagnosed with a general medical condition). Both conditions may be present in some individuals.

Bereavement is generally diagnosed instead of Adjustment Disorder when the reaction is an expectable response to the death of a loved one. The diagnosis of Adjustment Disorder may be appropriate when the reaction is in excess of, or more prolonged than, what would be expected. Adjustment Disorder should also be distinguished from other **nonpathological reactions** to stress that do not lead to marked distress in excess of what is expected and that do not cause significant impairment in social or occupational functioning.

- **Diagnostic criteria for Adjustment Disorders**

- A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- B. These symptoms or behaviors are clinically significant as evidenced by either of the following:
 - (1) marked distress that is in excess of what would be expected from exposure to the stressor
 - (2) significant impairment in social or occupational (academic) functioning
- C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
- D. The symptoms do not represent Bereavement.
- E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if:

Acute: if the disturbance lasts less than 6 months

Chronic: if the disturbance lasts for 6 months or longer

Diagnostic Criteria for Adjustment Disorders

Adjustment Disorders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(s) can be specified on Axis IV.

309.0 With Depressed Mood

309.24 With Anxiety

309.28 With Mixed Anxiety and Depressed Mood

309.3 With Disturbance of Conduct

309.4 With Mixed Disturbance of Emotions and Conduct

309.9 Unspecified

FEDERAL REQUIREMENTS

of citations per Region

F248 F250 F285 F319 F406**REGIONS**

of NFs w/ over 50%

Residents with Mental Illness

RO-I	7	0	1	0	0	0
RO-II	0	0	0	0	0	0
RO-III	8	0	0	0	0	0
RO-IV	10	1	2	0	0	0
RO-V	102	6	8	2	4	5
RO-VI	34	2	3	0	1	0
RO-VII	24	1	2	0	3	4
RO-VIII	3	1	0	0	1	0
RO-IX	48	7	9	1	1	1
RO-X	2	0	0	0	0	0

TOTAL	238	18	25			
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MENTAL ILLNESS IN NURSING FACILITIES

JULY 20, 2001

CMS Multimedia Broadcast

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CMS Chicago Regional Office V

- 1- **CHART with the data tags listed**
- 2 **TASK 1 - OFF SITE SURVEY PREPARATION**
3. **TASK 3 - INITIAL TOUR**
4. **TASK 4 - SAMPLE SELECTION**
5. **TASK 5C - RESIDENT REVIEW**
6. **F248-Activities**

F250-Social Services

F285-PASRR

F319-Mental and psychosocial functioning

F406-Specialized rehabilitative services

7. **"If specialized rehabilitative services such as mental health rehabilitative services for mental illness and mental retardation are required in the resident's comprehensive plan of care, the facility must provide the required services or obtain the required services or obtain the required services from an outside resource."**

8. **42 CFR 483.120 "Specialized services means the services specified by the State, which, combined with services provided by the NF, results in continuous and aggressive implementation of an individualized plan of care which includes a physician, qualified mental health professionals, and as appropriate other professionals".**
9. **"A nursing facility must not admit, on or after January 1, 1989, any new resident with mental illness...unless the State mental health authority has determined that ...the individual requires the level of services provided by a nursing facility; and if the individual requires such level of services, whether the individual requires specialized services for mental illness."**
10. **CFR 483.128**
11. **CFR 483.102(b)(1)**
12. **"The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident".**
13. **"The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident"**

"Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem"

EXERCISE

INSTRUCTIONS: Circle the F-tag that is most appropriate for each paragraph of "evidence".

1.) R13 has a diagnosis of Schizophrenic affective Disorder. R13 RAP identified "proceed with care plan" for activities. RAP summary states proceed with care planning. R13 has no activities care plan written. Physicians orders states may participate in activities including the fitness program. Recent Nursing notes and surveyor observations on 5/19 and 5/20 found R13 lying in bed declining to participate in the planned activities. Interview with R 13 revealed that she did not like the games, music and storytelling offered by activities. A review of the social service notes dated 9/2/00 reflected the resident's interests were gardening, pets and painting. There were no attempts to provide this resident with an activity program to meet her interests and needs.

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2) According to nurses notes on 10-09-00 at 9:30am, R6 was notified of the death of R6's brother. Nurses notes state, "R6 very tearful." "I'm really worried about myself now. We were very close." R6 has a diagnosis of Anxiety Disorder.

Ativan was ordered by the physician and administered without attempting alternative interventions first. R6 requested staff nurse to check her pulse frequently and exhibited anxiety by stating "I am so worried." On 10-9-00 on the evening shift R6 remained tearful. On 10-13-00 on the evening shift, R6 had an became verbally abusive. Subsequent interdisciplinary progress notes continue to describe the resident as "tearful" and "depressed". There is no evidence either through documentation, staff or resident interviews of any support or counseling was offered. Interview with R6 on 10-16-00 indicated the resident is still anxious and depressed and had not been seen by social services. On 10-13-00 social services note state R6 has "accepted his death in a calm manner. Continue to observe for changes in condition."

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3.) A review of the facility's activity calendars far March and April 2001 reflects activities to be sparse with 1 to 2 activities per month. Examples of activities offered included: Bingo, Open Leisure and Banking. On 4/24/01 at 10am only one resident was observed participating during the scheduled activity, Aerobics. Other residents were observed to be smoking. Additional observations throughout the survey week showed a maximum of 5 residents participating in activities. The majority of residents spent their time smoking or sleeping. The facility has identified 99 of 125 residents with mental illnesses or developmental disability diagnoses, ranging from young to elderly. Interviews with staff and residents confirmed the facility does not have activities aimed at meeting the mental and psychosocial needs of this population.

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4.) R2 has a diagnosis of Bipolar Personality Disorder. The MDS dated 12/20/00 has "average time involved in activities" scored as "None". The care-plan state "resident refused to participate in psychosocial groups and activities because of socially paranoid ideations". During individual interview, R2 states she did not want to attend the activity. She also said the place is very depressing and that she is not interested in the activities offered at the facility. Activities were not provided to address this individual's interests or needs. In addition, the care plan has not been altered since inception on 12/28/00 in order to plan for the provision of appropriate activities for this resident.

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5.) In 17 of 17 medical records of residents with MI diagnoses reviewed, Preadmission Screening (PAS) reports were not present in the clinical records. When questioned, the staff stated the reports were not being completed prior to admission.

In addition, there was no documentation in the clinical records reviewed to indicate that the residents were exempt from screening.

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6.) R9 has the diagnosis of schizophrenia and depression. According to the medical record, R9 experiences cyclical behaviors. Psychological evaluation dated 2/20/01 states, "To facilitate patient's adjustment to facility, encourage contact between R9 and family members.. verbalizes missing family...lack of family contacts is a depressing aspect of the living situation." R9s plan of care does not reflect the need for family involvement. Staff indicated that they call the family occasionally but only when R9 exhibits behaviors.

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7.) R14 had a diagnosis of mental illness, and the PASRR recommended workshop involvement. The care plan dated 8/19/00 identified workshop 5 days a week to maintain mental health stability. At the time of the survey on 11/15/00 a referral for this resident had not been made. On each day of the survey, R14 was observed sitting alone in his room with lights out and curtains drawn.

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8.) R7's assessment indicates that this resident is a good candidate for workshop. R7 has a social service goal dated six months ago to "attend day program." Although the social worker arranged for this resident to attend day program services, the resident has never attended and there is no documentation in the record as to why the services has not been provided. During the interview R7 stated the he/she would like to attend a workshop .

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9.) R1 was readmitted 3/19/01 from the psychiatric unit following a change in mental status. The facility did not refer this individual to the screening agency to evaluate whether or not R1's change in mental status was sufficient to merit specialized services for mental illness. On 4/3/01, R1 was again admitted to the locked psychiatric unit.

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10.) Based on a family interview, R1 was depressed about the recent death of her/his sister. R1 only speaks Cambodian. It was determined that she/he was in need of psychological services by the interdisciplinary team due to depression and inability to express needs due to the language barrier. Documentation showed that the R1 was being seen by a facility contracted psychologist monthly. However, the psychologist did not speak the residents' language and the facility staff was unable to explain how R1 was benefiting from the sessions.

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11.) R2 came to this facility on 10/29/00 from a rehabilitation hospital with multiple psychiatric diagnoses, medications and symptoms. Testing and evaluation in the rehabilitation hospital had suggested this individual would meet the PASRR criteria for mental illness. The preadmission evaluation and determination were required as to whether or not R2 could be admitted to a nursing facility and if they would need specialized services for mental illness. No preadmission referral was made until more than two weeks following admission. The screening

agency did not do a Level II full evaluation due to the limited amount of information provided by the facility. For example, the information regarding the results of the hospital testing was not shared, therefore the screening agency only did a partial screen for mental illness.

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12.) R#26 was admitted to the facility in March 2001 with a diagnosis of schizophrenia. The comprehensive assessment of the resident by the facility identified multiple problems with mood and behavior. Nursing notes documented tearfulness, pain control problems, and behavior problems. The facility arranged for a session with a contract agency on 5/1/01; the resident refused to go. There was no further documented evidence that the facility attempted alternative measures to meet the mood/behavior and psychosocial needs of this resident.

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13.) R27 has a diagnosis of Repressed Chronic Schizophrenia. The medical record describes the following behaviors: pacing throughout the facility, frequently screaming, sexually preoccupied and vulgar, boxing with herself, violent rage, non-compliant with treatment, going in/out of other residents' rooms rummaging through their things looking for cigarettes, money, and or disruptive at bedtime, refuses to shower, eat meals on time or wear appropriate clothing, striking out and becoming verbally abusive with other residents. On 4/23/01 at 10:30am R27 was pacing up and down the corridor going in and out of resident rooms. On 4/24/01 10am, surveyor knocked on door to resident's room. Surveyor observed R27 in bed, no sheets on the bed, resident yelled, 'leave me alone' and got out of bed to chase surveyor out of room. Record review reflects care plan approach for R27 to meet with Mental Health Counselor one time a week. Staff interviews revealed meetings were not scheduled and no other additional counseling or therapeutic programs were provided to the resident. Although this resident

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